Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

January 2010

Revisions to the Interpretive Guidance for F441: Infection Control

By Joan Coleman

On, July 20, 2009, the Centers for Medicare and Medicaid Services (CMS) reissued Transmittal 51 on revisions to the Interpretive Guidance for F441: Infection Control (with an effective date of Sept. 30, 2009). Since this time, CMS has made a few additional revisions to the Interpretive Guidance for F441. On, Dec. 2, 2009, CMS issued Transmittal 55, the final version of the Interpretive Guidance for F441. The Interpretive Guidance for F441 directs surveyors to focus on infection prevention and control and on sanitary practices in all departments.

The long-term care federal regulations at Tag 441 state the following:

Infection Control

The facility must establish and maintain an Infection Control Program designed to provide a safe and comfortable environment and to help prevent the development and transmission of disease and infection.

Infection Control Program

The facility must establish an Infection Control Program under which it:

1. *Investigates, controls and prevents infections in the facility.*
2. *Decides what procedures, such as isolation, should be applied to an individual resident.*
3. *Maintains a record of incidents and corrective actions related to infections.*

Preventing Spread of Infection

1. *When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.*
2. *The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.*
3. *The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.*

Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

During each recertification survey, and other surveys when indicated, the survey team will be:

- Reviewing the facility's record of incidents of

(Continued on page 2)

INSIDE THIS ISSUE:

Long Term Care Highlights

January 2010

(Continued from page 1)

infection and related corrective actions to help determine whether the facility is identifying, recording and analyzing infections.

- Reviewing all of the facility's infection control policies and procedures (e.g., nursing, dietary, rehab, housekeeping, environment, laundry, etc.).
- Observing various disciplines (nursing, dietary, housekeeping, etc.) to determine if the staff follow appropriate infection control practices and transmission based precaution procedures.
- Interviewing the resident, family, or responsible party to the extent possible to identify, as appropriate, whether they have received education and information about infection control practices, such as appropriate hand hygiene and any special precautions applicable to the resident.
- Interviewing direct care staff.
- Reviewing records of sampled residents.
- Reviewing the employees' records to determine if employees receive initial and ongoing employee infection control training regarding critical elements of the infection control plan.
- Reviewing the facility's evaluation of the appropriateness and effectiveness of antibiotics for residents who are identified as receiving antibiotics.

The direction from CMS is that all infection prevention and control practices in long-term care facilities reflect current Centers for Disease Control and Prevention (CDC) guidelines. However, in regard to hand hygiene and hand washing practices, the expectation of CMS is that long-term care facilities **must** follow the Interpretive Guidance under F441.

Reference:
State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities.

Hand Washing and Cleaning Glucose Meters

By Joan Coleman

When is hand washing with soap and water required?

The Interpretive Guidelines for F441 identify the following in regard to hand hygiene:

- Hand hygiene is a general term that applies to washing hands with water and either plain soap or soap/detergent containing an antiseptic agent; or thoroughly applying an alcohol-based hand rub (ABHR).
- Hand washing refers to washing hands with plain (i.e. nonantimicrobial) soap and water.

Hand hygiene continues to be the primary means of preventing the transmission of infection. **The following is a list of some situations that require hand washing with soap and water:**

- When hands are visibly soiled.
- Before and after eating or handling food.
- After personal use of the toilet.
- After performing your personal hygiene.
- Before and after assisting a resident with toileting (cleansing/wiping perineal area or providing incontinent cares).
- After contact with a resident with infectious diarrhea, including but not limited to infections caused by norovirus, salmonella, shigella and C. difficile.
- Before and after administering eye drops.

The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors and other antiseptic agents have poor activity against spores. Our department has made contact with the Centers for Medicare & Medicaid Services

(Continued on page 3)

(Continued from page 2)

(CMS) to clarify variances between what the CDC and CMS expects for hand hygiene / hand washing. The expectation of CMS is all long-term care facilities **must** follow the F441 Interpretive Guidance in regard to hand hygiene / hand washing to be in compliance with the regulations.

What is the appropriate method for cleaning glucose meters between each resident? Is cleaning the glucose meter with an alcohol swab effective?

Alcohol is not an approved product for cleaning environmental areas potentially contaminated with blood-borne pathogens. When cleaning a glucose meter, or any other object potentially contaminated with blood, you must use either an Environmental Protection Agency (EPA) approved germicidal disinfectant that is labeled effective against TB or HBV, or a l:10 bleach to water (minimal) concentration. The easiest method is for the facilities to have disposable wipes with bleach.

Blood Glucose Monitoring Devices

The Rate Setting Manual for Nursing Facilities, published by the North Dakota Department of Human Services, Medical Services Division, dated July 2006 states: items to be supplied by facility and includable on cost report includes:

- Blood Glucose Monitoring Device, test strips and supplies (excluding diabetic).

Items excludable as routine drugs, supplies and DME for nursing facilities and not includable on cost report includes:

- Diabetic Supplies routinely covered under Medicare Part B or D, including lancets, monitors, strips, syringes, needles and swabs.

Infection Control and Prevention Guidelines for Influenza in Long-Term Care Facilities

Residents in nursing homes are at higher risk of complications related to influenza and influenza-like infections. Both seasonal and swine-origin influenza A H1N1,as well as other disease-causing organisms, can be transported into a facility by personnel, new residents or visitors. It is important to identify illnesses early so actions to control the spread can be started quickly.

Modes of Influenza Transmission:

The spread of influenza virus occurs through droplet transmission, when respiratory droplets from infected indivduals directly fall within 3 to 6 feet (may be up to 10 feet) from the infected person after coughing, sneezing or talking. These droplets infect the mucus membranes (eyes, nose or mouth) of others, or contaminate surfaces and items in the infected person's environment. The droplets can be picked up from surfaces and indirectly spread to mucus membranes after touching these contaminated surfaces.

Droplet transmission differs from airborne transmission, which is the ability of tiny respiratory droplets to float in the air and travel further distances. Airborne transmission of influenza viruses is unknown.

(Continued on page 4)

(Continued from page 3)

Control and Prevention of Influenza Viruses:

1. Encourage and provide annual influenza vaccination against seasonal and novel strains of influenza to residents and employees.
2. Focus on early recognition of residents with influenza-like symptoms. Screen and monitor new residents and those returning after temporary absences. Encourage residents to report symptoms promptly, especially fever, cough, sore throat, headache or body aches.

3. Educate residents to follow respiratory hygiene, cough etiquette and hand hygiene, and ensure adequate supplies of tissues, waste containers and hand hygiene materials.
4. Use standard precautions when caring for all resident, including those with influenza-like illness.
5. Use droplet isolation precautions in addition to standard precautions when caring for residents with suspected or confirmed influenza until at least 24 hours after they are free of fever (defined as > 100 degrees F or 37.8 degrees C) or signs of a fever without the use of fever-reducing medications.

Staff Should Use Safe Personal Protective Equipment (PPE) Removal Sequence. Do Not Touch the Outside of PPE Items:

1. Gloves:
   a. Grasp outside of glove with opposite gloved hand and peel off.
   b. Hold removed glove in gloved hand.
   c. Slide fingers of ungloved hand under remaining glove at wrist.
   d. Peel second glove off over first glove and discard into trash receptacle.
2. Goggles or Face Shield:
   a. Grasp head band or ear pieces.
   b. Place in designated receptacle for reprocessing or in waste container.
3. Gown:
   a. Unfasten ties.
   b. Pull away from neck and shoulders, touching inside of gown only.
   c. Turn gown inside out.
   d. Fold or roll into a bundle and discard.
4. Mask or Respirator:
   a. Grasp bottom ties or elastic band, then top, and remove without contaminating face.

Environmental Infection Control:

1. Use routine cleaning and disinfection strategies during influenza seasons.
2. Focus on frequently touched surfaces.
3. For further guidance, consult this CDC guidance:
www.cdc.gov/ncidod/dhqp/gl_environinfection.html

Preventing Exposures From Employees and Visitors:

1. Post signage at all building entry points instructing employees and visitors to report influenza-like illness (ILI) symptoms at the first opportunity. Consider having personnel verbally and visually screen visitors for ILI symptoms.
2. Post educational materials in appropriate languages regarding respiratory hygiene/cough etiquette, and provide supplies to perform these actions.

(Continued on page 5)

(Continued from page 4)

Personnel Surveillance:

1. Monitor personnel daily for signs and symptoms of ILI. If an employee becomes ill while at work, they should cease working with residents, and notify their supervisor.
2. Healthcare personnel who have had an unprotected exposure to influenza may continue to work as long as they are asymptomatic and should contact their primary care provider regarding recommendations for antiviral prophylaxis.

Management of Ill Personnel:

1. Instruct all workers to stay home if they are sick with ILI symptoms. Healthcare workers with ILI should be excluded from work for at least 24 hours after they no longer have a fever (defined as > 100 degrees F or 37.8 degrees C) or signs of a fever without the use of fever-reducing medicines. Those who work in areas where the residents are considered severely immunocompromised should be considered for temporary reassignment or exclusion from work for seven days from symptom onset or until symptoms have resolved, whichever is longer.
2. Non-healthcare employees with ILI should stay home and not return to work until at least 24 hours after they are free of fever (defined as >100 degrees F or 37.8 degrees C) or signs of a fever without the use of fever-reducing medications.
3. Have time-off and return to work policies and procedures in place for employees who are asked to stay home because of fever and respiratory symptoms.

Source: Oklahoma State Department of Health 10/2009

Infection Prevention and Control Information

General Infection Control Measures

Implementation and adherence to infection control practices are the keys to preventing the transmission of healthcare associated infections, including respiratory diseases spread by droplets or airborne routes. Recommended infection control practices includes the following:

- Hand hygiene.
- Standard precautions/transmission-based precautions (Contact, Droplet, Airborne).
- Respiratory.

When followed properly, each practice decreases the risk of spreading common respiratory pathogens. However, hand hygiene is the single most effective means of preventing the spread of all infections among residents/patients and personnel.

Hand Hygiene

Proper hand hygiene is the most effective way to prevent the spread of infection.

- Detailed hand hygiene information is available in the revised Interpretive Guidance for F441 Infection Control.
- Avoid wearing artificial fingernails when caring for residents/patients at high risk for infection, and keep natural nail tips less than one-fourth inches long.
- Wear gloves when contact could occur with blood or other potentially infectious materials, mucous membranes and nonintact skin.

(Continued on page 6)

(Continued from page 5)

- Remove gloves after caring for a resident/patient. Always perform hand hygiene after removing gloves. Do not wear the same pair of gloves for the care of more than one resident/patient.
- Change gloves during resident/patient care if moving from a contaminated body site to a clean body site.

Standard Precautions

Standard precautions and transmission-based precautions are designed to prevent the transmission of infections microorganisms. They require the use of work practice controls and protective apparel for all contact with blood and body substances, and airborne infection isolation (A.I.I.) droplet and contact precautions for residents/patients with diseases known to be transmitted in whole or in part by those routes. Standard precautions include consistent and prudent preventative measures to be used at all times. Regardless of a resident's/patient's infection status. *Standard Precautions* include the following:

Hand hygiene: Practice hand hygiene after touching blood, body fluids, secretions, excretions or contaminated items *whether or not gloves are worn*. Perform hand hygiene / hand washing as indicated in the Interpretive Guidance for F441.

Gloves: Wear gloves (clean, nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions or contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin.

Change gloves between tasks and procedures. *Practice hand hygiene whenever gloves are removed.*

Mask, eye protection/face shield: Wear a mask and adequate eye protection (eyeglasses are not acceptable) or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures and resident/patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

Gown: Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and resident/patient care activities that are likely to generate splashed or sprays of blood, body fluids, secretions, or excretions. Remove a soiled gown as promptly as possible, with care to avoid contamination of clothing, and perform hand hygiene / hand washing as indicated in the Interpretive Guidance for F441.

Resident/Patient care equipment: Handle used resident/patient care equipment soiled with blood, body fluids, secretions or excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to one's self, other residents/patients and environments. Ensure that reusable equipment is not used for the care of another resident/patient until it has been cleaned and sanitized appropriately. Ensure that single-use items are discarded properly.

Droplet Precautions

In addition to standard precautions, use droplet precautions for a resident/patient known or suspected to be infected with microorganisms

(Continued on page 7)

(Continued from page 6)

transmitted by droplets (large-particle, wet droplets) that can be generated by the resident/patient during coughing, sneezing, talking or in the course of procedures.

Examples of disease/organisms requiring droplet precautions include:

- Influenza.
- Invasive Hemophilus influenza disease: meningitis, pneumonia (in infants & small children) and epiglottitis.
- Invasive Neisseria meningitides disease: meningitis, pneumonia and bacteremia
- Mycoplasma.
- Group A streptococcal pneumonia, pharnygitis, or scarlet fever in infants and young children.
- Adenovirus infection; also requires contact precautions.
- Rubella.
- Parvovirus B19.

Droplet Precautions include the following:

Resident/Patient placement: Place the resident/patient in a private room. When a private room is not available, place the resident/patient in a room with a resident/patient who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least six feet between the infected resident/patient and other residents/patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open.

Mask: In addition to standard precautions, wear a mask or respirator when working within 3 to 6 feet of the resident/patient. (You may want to implement the wearing of a mask to enter the room).

Resident/Patient transport: Limit the movement and transport of the resident/patient from the room to essential purposes only. If transport or movement is necessary, minimize resident/patient dispersal of droplets by masking the resident/patient, if possible.

Contact Precautions

In addition to standard precautions, contact precautions should be used for the care of resident/patients known or suspected to have illnesses that can be spread by usual contact with an infected person or the surfaces or resident/patient care items in the room.

Examples of disease/organisms requiring contact precautions include:

- Parainfluenza virus infection.
- Respiratory syncytial virus infection.
- Varicella (chickenpox); also requires airborne infection isolation.
- Herpes zoster (disseminated in the immunocompromised host); also requires airborne infection isolation.
- Hepatitis A.
- Norovirus infections.
- Rotovirus infections.

Contact precautions include the following:

Gloves and hand hygiene: Wear gloves when entering the room. During the course of providing care for a resident/patient, change gloves after having contact with infectious material. Remove gloves before leaving the resident's/patient's room and perform hand hygiene / hand washing as indicated in the

(Continued on page 8)

(Continued from page 7)

Interpretive Guidance for F441. After glove removal and hand hygiene/hand washing, ensure that hands do not touch potentially contaminated surfaces or items in the resident's/patient's room.

Gown: Wear a gown when entering the room. Remove the gown before leaving the resident's/patient's environment. After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces. Wash or decontaminate hands.

Resident/Patient transport: Limit the movement of the resident/patient from the room to essential purposes only. During transport, ensure that all precautions are maintained.

Resident/Patient care equipment: When possible, dedicate the use of noncritical resident/patient care equipment to a single resident/patient (or cohort of residents/patients infected or colonized with the pathogen requiring precautions) to avoid sharing among residents/patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another resident/patient.

Resident/Patient placement: Place the resident/patient in a private room. If a private room is not available, place the resident/patient in a room with other residents/patients with the same illness (cohorting). Apply appropriate cleaning and decontamination of the room after the resident/patient vacates it.

Airborne Infection Isolation

Residents/Patients requiring airborne infection isolation would be transferred to a hospital as they must be in a private room with special air handling and ventilation (negative pressure).

Respiratory Hygiene/Cough Etiquette

"Respiratory hygiene" is a term that has been adopted by the Centers for Disease Control and Prevention (CDC) to describe measures that can be taken to decrease the risk of spreading respiratory pathogens. A universal "respiratory hygiene/cough etiquette" strategy for a healthcare facility should be followed.

Source: Massachusetts Department of Public Health (September 2007) and State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities.

CDC Risk Levels Associated With Medical Instruments

- Critical items (e.g., needles, intravenous catheters, indwelling urinary catheters). The equipment must be sterile when used.
- Semi-critical items (e.g., thermometers, podiatry equipment, electric razors) are defined as those objects that touch mucous membranes or skin that is not intact. Such items require meticulous cleaning followed by high-level disinfection treatment, or may be sterilized.
- Non-critical items (e.g., stethoscopes, blood pressure cuffs, over-bed tables) are defined as those that come in contact with intact skin or do not contact the resident. They require low level disinfection by cleaning periodically and after visible soiling with an EPA disinfectant or germicide approved for health care settings.

Devices labeled by the manufacturer for single use are never to be reused.

Reference:
State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities.

The Use of Hand Antiseptics in the Dietary Department

Proper hand washing reduces the spread of fecal-oral pathogens from the hands of a food employee to foods. Hand washing can also help to reduce the transmission of other pathogens from environmental sources.

What is effective hand washing? It is the act of cleansing hands by applying soap and water, rubbing them together vigorously, rinsing them with clean water, and thoroughly drying them. This process gets rid of dirt and germs. Every hand washing stage is important and effectively contributes to soil removal and reduction of microorganisms that can cause illness.

Can hand antiseptics (hand sanitizers) be used in place of adequate hand washing in food establishments? No. Hand antiseptics should be used only in addition to proper hand washing.

The Food and Drug Administration (FDA) has developed an Employee Health and Personal Hygiene Handbook to encourage practices and behaviors that can help prevent food employees from spreading viruses and bacteria to food. To receive a copy of this handbook, e-mail CFSAN-PublicationRe@fda.hhs.gov Ask for publication number RFS04. Title: *Employee Health and Personal Hygiene Handbook*

Source: Food and Drug Administration Employee Health and Personal Hygiene Handbook.

Bare Hand Contact with Food during Mealtime

Question: Is it acceptable for staff members to touch food (e.g., bread or toast) directly with bare hands when assisting residents with meals?
Answer: No. Staff members should use utensils, napkins or dining tissue paper.

Minimum Data Set Questions and Answers

By Joan Coleman
State RAI Coordinator

Q & A on Section E

Question: If a resident is exhibiting repetitive physical movements due to a physical disease process (i.e. involuntary movements related to Parkinson's or Huntington's), are these coded under E1n?
Answer: No. The Centers for Medicare and Medicaid Services (CMS) has stated that these would not be coded here. The intent of this section is indicator of behaviors.

Q & A on Section K

Question: I have been told that if a resident wore dentures, you would still code for a chewing problem, as the dentures are the solution but the problem still exists. Is this correct?
Answer: The presence of dentures without any evidence of oral problems does not mean that there is a chewing problem.

Question: For a hospice patient, is it acceptable to code "planned weight change" since the weight loss is expected?
Answer: This would ***NOT*** be coded on the MDS as a planned weight change. It is not a "program" of weight change as identified in the manual, but an outcome of a disease process.

Question: When I code K5a, can I add IV medication fluid totals for the 7 day look back period?
Answer: The fluid used to administer IV medication can only be counted in K5a if it is for hydration or nutrition purposes and if it

(Continued on page 10)

(Continued from page 9)

was not provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.

Q & A on P7 Physician Visits and P8 Physician Orders

Question: Can hospice nurses and/or wound nurses be considered clinical nurse specialists working in collaboration with physicians for purposes of counting physician visits (the number of days)?

Answer: Hospice nurses and wound care nurses would not automatically be considered as clinical nurse specialists or nurse practitioners for coding the MDS in P7 or P8. Clinical nurse specialists and nurse practitioners have advanced clinical training at the master's or doctorate level and pass national testing to obtain those designations. A hospice or wound care nurse may be a clinical nurse specialists or a nurse practitioner, but it would be based on their advanced education, training and testing.

Question: Can orders/visits by optometrists be counted and coded in P7 or P8?

Answer: No. Optometrists (also known as doctors of optometry or ODs) are not physicians or physician extenders as defined by the RAI manual and are excluded from being counted in P7 or P8.

Q & A on Section W

Question: A resident received the flu vaccine on Sept. 21, 2009. I am working on his quarterly MDS assessment. The way I read the MDS form, I would not code the flu vaccine since it was not given during the flu season of 10/01/09 through 03/01/2009. Is that correct?

Answer: This section of the RAI User's Manual was updated in July 2008 and states the flu season begins when the vaccine is made available to the public. The intent of the question is to collect data on the number of elderly who were vaccinated for the current flu season each year. Therefore, you would code this as the resident did receive the flu vaccine during the current flu season.

CERTIFIED NURSE AIDE REGISTRY UPDATE

By Cindy Kupfer and Rocksanne Peterson

- When using the on-line renewal system, please use your facility's e-mail address, even when you are helping an employee.
- The last date worked, does **not have** to be an eight hour shift. The *total* of eight hours worked, could be a combination of shifts within the past 24 months.

Long Term Care Highlights is published by:
North Dakota Department of Health
Division of Health Facilities
600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200
Phone: 701.328.2352
Fax: 701.328.1890
Website: www.ndhealth.gov

Terry L. Dwelle, M.D., MPHTM, State Health Officer
Darleen Bartz, PhD, Chief, Health Resources Section
Bruce Pritschet, Director, Division of Health Facilities
Lucille Torpen, LTC Program Manager
Cindy Kupfer, Newsletter Design